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Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
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August 14, 2003

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

SUBJECT: **JULY 16, 2003 INFORMATION REQUEST BY HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE**

As you may be aware from recent news coverage, on July 16, 2003 the House of Representatives Committee on Energy and Commerce issued a letter (attached) to 20 large health systems across the nation. The Department of Health Services was among the organizations that received this request. The letter announces their investigation into "...the billing practices of certain medical providers under which the uninsured are expected to pay substantially higher amounts for medical services than third-party health plans such as medical insurers, health maintenance organizations, and preferred provider organizations (collectively, 'third-party health plans'), or government health care programs." As part of their investigation, the Committee requested an extensive array of data, records and narrative explanations regarding the medical service charging practices of these health systems, all by July 31, 2003.

In announcing their investigation, the Committee cites its concern that rates charged for medical services "...are often inflated far beyond their actual costs and reasonable profit due, in part, by providers' need to make up for the steep discounts from charge master prices demanded by third-party health plans. For example, according to the U.S. Department of Health and Human Services, California urban hospitals in 2002 averaged a 304.8 percent mark-up over actual cost in their master charge list prices. While the third-party plans have bargained to pay far less than retail charges, individual patients are expected to pay full, undiscounted 'sticker' price."

By comparison, the Department's average hospital inpatient services are marked-up over their respective costs by about 224 percent, the average hospital outpatient charges by about 57 percent, and the average emergency room charges by about 2 percent. The rationale for our charges in excess of cost is not to "profit" from our self-paying patients. The vast majority of patients pay only a small fraction or nothing of these charges by participating in the Department's reduced cost payment plans, such as ATP and ORSA, or by just not paying the bill despite our rigorous collection efforts, which are principally aimed at encouraging patients to disclose or apply for coverage, such as Medi-Cal.

As the Department has advised the Board on many occasions over the past several years, inpatient charges over cost have been raised due to a federal requirement that Medi-Cal inpatient charges must exceed the total non-disproportionate share hospital gross reimbursement the Department receives for Medi-Cal inpatient services. Since the gross reimbursement includes SB1255 payments, for which our gross reimbursement is more than double the net reimbursement, and this has been a growing source of funds, the Department has had to raise charges substantially to meet the federal requirement.

For non-inpatient services, DHS charges have historically exceeded costs primarily to ensure that we meet the lower of cost or charges reimbursement limitation for Medicare. Charges do not vary by payer due to our historical understanding that Medicare requires charges to be the same across payer classes and the fact that disparate charges could create practical difficulties in instances where patients are covered by multiple payers.

The Department's initial assessment of the request indicates that hundreds, if not thousands, of staff hours would be required over several weeks, if not months, to respond to this request in its current form. Further, the request has several points of ambiguity regarding the interpretation of the data elements to be provided. Since our assessment is generally shared by all 20 health systems, the American Hospital Association (AHA) has been aggressively pursuing relief from both the scope of information requested, as well as a substantial extension of the due date for the responses. AHA has retained special legal counsel to assist them in negotiating with the Committee in this regard. They also have conducted a series of conference calls with representatives of the affected health systems to gain a broad perspective of their concerns and ability/inability to comply, and to provide an update of the status of AHA's discussions with Committee representatives.

The most recent of these calls was conducted this past Friday, July 25. Per the call, the Committee is willing to:

- extend the due date beyond July 31, but no new date has yet been set;
- accept requested information on a flow basis;
- drop the request that data be reported quarterly; and,
- reduce the requested scope of documentation.

AHA is still pursuing a reduction in the number of years covered by the request.

The Department is working actively with County Counsel to assess and prepare our response to this request and I will keep you apprised as developments occur.

Please let me know if you have any questions or desire further information.

TLG:gww

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

(COMMITTEE ON ENERGY AND COMMERCE)

ONE HUNDRED EIGHTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

W.J. "BILLY" TAUZIN, LOUISIANA,
CHAIRMAN

July 16, 2003

Jonathan E. Fielding, M.D., M.P.H., MBA
Director of Public Health & Health Officer
Los Angeles County, Department of Health Services
13 N. Figueroa Street
Room 909
Los Angeles, CA 90012-2602

Dear Dr. Fielding:

The Committee on Energy and Commerce is conducting an investigation into the billing practices of certain medical providers under which the uninsured are expected to pay substantially higher amounts for medical services than third-party health plans such as medical insurers, health maintenance organizations, and preferred provider organizations (collectively, "third-party health plans"), or government health care programs. These practices raise significant public health and consumer protection issues. The uninsured seem caught in the middle of the sophisticated and complicated forces driving health care financing including government entitlements, managed care, rising costs and shrinking public funds. The Committee is approaching your hospital system, as well as other large acute care hospital systems, to obtain further information about these issues.

We understand that medical providers commonly interpret Federal law to require the establishment of uniform charge master lists setting forth rates for each of their services. Yet, based on the Committee's preliminary investigation, these rates are often inflated far beyond their actual costs and reasonable profit due, in part, by the providers' need to make up for the steep discounts from charge master prices demanded by the third-party health plans. For example, according to the U.S. Department of Health and Human Services, California urban hospitals in 2002 averaged a 304.8% mark-up over actual costs in their master charge list prices. While the third-party health plans have bargained to pay far less than these retail charges, individual uninsured patients are expected to pay this full, undiscounted, "sticker" price.

This pricing system also may have other unintended and undesirable consequences. Because these "self-pay" individuals receive bills much higher than other patients for the exact same services, medical providers may be generating a

disproportionate share of profit from this relatively small group of patients. Data published for the first time by the California Office of Statewide Health Planning and Development, which is part of the California Health and Human Services Agency, suggests that the 2001 net revenue of one hospital chain in that State, for its self-pay, uninsured and walk-in patients - who, as a whole, accounted for less than 2% of the chain's total patient population – accounted for as much as 35% of the chain's total profits in that State.

Further, while we recognize that Federal law also directs providers to seek full payment on all medical bills, we are concerned that the current system may give incentives to providers not to work with patients in developing payment plans and other structured arrangements.

In this regard, pursuant to Rules X and XI of the U.S. House of Representatives, please provide the Committee with the following records and information by July 31, 2003. For the purpose of responding to these requests, please observe the following definitions: "you" or "your system" means both your parent system as well as individually each acute care hospital within this system; "self-pay" means any patient who (1) has no applicable coverage through a third-party health plan, (2) is not enrolled or eligible for any government-sponsored program such as Medicare, Medicaid, or state or county indigent care, and (3) is not eligible for charity care; "elective procedure" means any medical care sought only for aesthetic or physical enhancement such as cosmetic surgery or eye correction but not including reconstruction or any such procedure recommended by a medical provider for rehabilitation or health reasons; "uninsured" means any self-pay patient not undergoing an elective procedure; "charity care" means any financial assistance or gift, from any source, which directly covers all or part of an individual patient's medical expenses submitted to that patient for payment but not mean any general payments to you for the indirect benefit of patients in the form of facilities or other such overhead; and "payment planning assistance" means any type of counseling or assistance to schedule, structure or tailor the payment of medical accounts based on the financial circumstances of a particular patient.

Please note that Requests No. 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, and 20 ask for narrative responses or a statement of specific data. The breadth and timeliness of this investigation require you to prepare and submit complete written responses, as appropriate. To avoid any doubt, answers by way of simple reference to produced documents will be considered insufficient and incomplete for the purposes of this investigation.

Finally, for the purposes of these requests, please do not provide any patient names or patient specific or individually identifiable health information. Also, with respect to questions regarding matters of billing, payment or collection, please do not produce any records which relate only to the accounts of individual, specific patients.

1. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information for each acute care hospital within your system, using the format of the chart below.

   a. Net operating income;
   b. Total patient days;
   c. Net revenue collected per patient day from;
      i. Fee-for-service Medicare
      ii. Medicare+Choice
   d. Net revenue collected per patient day from;
      i. Fee-for-service Medicaid
      ii. Managed Medicaid
   e. Net revenue collected per patient day from third-party payors from;
      i. Traditional insurance
      ii. Managed care insurance
   f. For uninsured patients.
      i. Net revenue collected per patient day
      ii. Gross billing per patient day
      iii. Number of patient days for uninsured patients.

		(a)	(b)	(c)		(d)		(e)		(f)		
				(c) i	(c) ii	(d) i	(d) ii	(e) i	(e) ii	(f) i	(f) ii	(f) iii
Hospital Name	1Q98											
	2Q98											
	etc.											

2. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information, in aggregate, for your system nationally, using the format of the chart above in Request No. 1.

   a. Net operating income;
   b. Total patient days;
   c. Net revenue collected per patient day from:
      i. Fee-for-service Medicare
      ii. Medicare+Choice
   d. Net revenue collected per patient day from;
      i. Fee-for-service Medicaid
      ii. Managed Medicaid
   e. Net revenue collected per patient day from third-party payors from:
      i. Traditional insurance
      ii. Managed care insurance
   f. For the uninsured:
      i. Net revenue collected per patient day
      ii. Gross billing per patient day
      iii. Number of patient days for uninsured patients.

3. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information, in aggregate, for your system in each State in which you provide acute care hospital medical services, using the format of the chart above in Request No. 1.

   a. Net operating income;
   b. Total patient days;
   c. Net revenue collected per patient day from:
      i. Fee-for-service Medicare
      ii. Medicare+Choice
   d. New revenue collected per patient day from;
      i. Fee-for-service Medicaid
      ii. Managed Medicaid
   e. Net revenue collected per patient day from third-party payors from:
      i. Traditional insurance
      ii. Managed care insurance
   f. For the uninsured:
      i. Net revenue collected per patient day
      ii. Gross billing per patient day
      iii. Number of patient days for uninsured patients.

4. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information for each acute care hospital within your system, using the format of the chart below.

   a. The total gross revenue from uninsured patients
   b. The total net revenue from uninsured patients
   c. The total net revenue collected from uninsured patients
      i. under any payment planning assistance program
      ii. through involuntary means such as debt collection
   d. For the deductions from uninsured revenue (gross revenue less net revenue) state:
      i. the total deductions from revenue
      ii. the amount claimed or otherwise identified bad debt
      iii. the amount of such bad debt recovered in any way through any state or federal fund, pool or resource
      iv. the amount of deductions from revenue claimed or otherwise identified as charity care

		(a)	(b)	(c)		(d)			
				(c) i	(c) ii	(d) i	(d) ii	(d) iii	(d) iv
Hospital Name	1Q98								
	2Q98								
	etc.								

5. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following for each acute care hospital in your system:

   a. the total disproportionate share hospital ("DSH") payment received; and
   b. whether the value of any bad debt or otherwise uncompensated services delivered to the uninsured formed any part of the basis or demonstrated need upon which the DSH payments under Medicaid and Medicare, were calculated and, if so, provide the value of such bad debt or services.

6. For the period beginning January 1, 1998, please state each source through which your system received any funds for bad debt or charity care on services provided to the uninsured.

   a. Please state whether line item charges in individual patient bills have ever been earmarked for bad debt pools, charity care pools, or any other such resource or state or local administered fund. If so, please describe this policy, practice or procedure.

7. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide, in chart format, the operating cost-to-charge ratios for the following:

   a. Each acute care hospital within your system;
   b. In aggregate, your system nationally; and
   c. In aggregate, your system in each State in which you provide acute care hospital medical services.

   Please provide unaudited numbers where audited numbers are not yet available.

8. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide, in chart format, the following for each acute care hospital within your system:

   a. the ten most billed (in terms of total gross charges) diagnostic related group codes of your system and the cost-to-charge ratio for each such code;
   b. the ten most billed (in terms of total gross charges) ambulatory payment classification codes of your system and the cost-to-charge ratio for each such code;
   c. the three revenue centers and/or profit centers with the lowest cost to charge ratios providing, as well, the relevant ratios.

9. For the period beginning January 1, 1998, to the present, please provide all records relating to any discussions, comparisons or analyses regarding differences between the payments made for medical services by uninsured patients and those paid by third-party health plans or government health care programs.

10. For the period beginning January 1, 1998, to the present, please provide all records relating to rates of collection or realization on bills from self-pay or uninsured patients.

11. Please state how your system identifies uninsured patients who are eligible for any charity care or payment planning assistance. Please also state how such eligible patients are notified of the availability of such charity care or payment planning assistance. Please describe any substantive changes or enhancements to the policies, procedures or practices relating to the eligibility, notification of availability and delivery (in terms of crediting the accounts of eligible patients) of charity care or payment planning assistance since January 1, 1998, including specific dates on which any such changes or enhancements came, or will come, into effect.

12. For the period beginning January 1, 1998, to the present, please provide all records relating to the eligibility, notification of availability and delivery (in terms of crediting the accounts of eligible patients) of charity care and payment planning assistance offered by your system.

13. Please describe any formula and/or methodology used to calculate or otherwise establish charge master rates in your system and state whether there have been any changes to such formulas and/or methodologies from January 1, 1998 to the present.

14. Please describe any policies, procedures or practices relating to availability, posting, dissemination, publication or production of your system's charge master rates to the public and/or current or prospective patients. Please also describe any substantive changes or enhancements to such policies, procedures or practices since January 1, 1998, including specific dates on which any such changes or enhancements came, or will come, into effect.

15. For the period beginning January 1, 1998, to the present, please provide all records relating to any policies, procedures or practices relating to availability, posting, dissemination, publication or production of your system's charge master rates to the public and/or current or prospective patients.

16. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented changes in charge master rates. This request includes, but is not limited to, any studies, reports or

recommendations concerning charge masters rates prepared by any third-party or consultant.

17. For the period beginning January 1, 1998, to the present, please provide all records relating to any discussions, comparisons or analyses of whether any proposed, considered or implemented charge master rates or applicable cost-to-charge ratios are consistent with state or federal law.

18. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented policy, plan, procedure or practice by which you might increase revenue or profit through changing the mix or ratios within your patient population in terms of responsible payor – *e.g.*, Medicare, uninsured, self-pay, or third-party health plans.

19. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented policy, plan, procedure or practice the intended effect or result of which would be to increase your amount of bad debt from self-pay or uninsured patients. ?

20. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please describe your policies, practices and procedures relating to outstanding patient bills (including, but not limited to, payment terms, interest rates, and debt collection), and provide all records relating thereto (including, but not limited to, all records relating to the use of collection agents and under what circumstances matters would be referred to such agents).

Please note that, for the purpose of responding to these requests, the terms "records" and "relating" should be interpreted in accordance with the attachment to this letter. If you have any questions, please contact Mark Paoletta, Chief Counsel for Oversight and Investigations, at (202) 225-2927 or Anthony M. Cooke, Majority Counsel for Oversight and Investigations, at (202) 226-2424.

Sincerely,

W.J. "Billy" Tauzin
Chairman

James C. Greenwood
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable John D. Dingell, Ranking Member
The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

ATTACHMENT

1. The term "records" is to be construed in the broadest sense and shall mean any written or graphic material, however produced or reproduced, of any kind or description, consisting of the original and any non-identical copy (whether different from the original because of notes made on or attached to such copy or otherwise) and drafts and both sides thereof, whether printed or recorded electronically or magnetically or stored in any type of data bank, including, but not limited to, the following: correspondence, memoranda, records, summaries of personal conversations or interviews, minutes or records of meetings or conferences, opinions or reports of consultants, projections, statistical statements, drafts, contracts, agreements, purchase orders, invoices, confirmations, telegraphs, telexes, agendas, books, notes, pamphlets, periodicals, reports, studies, evaluations, opinions, logs, diaries, desk calendars, appointment books, tape recordings, video recordings, e-mails, voice mails, computer tapes, or other computer stored matter, magnetic tapes, microfilm, microfiche, punch cards, all other records kept by electronic, photographic, or mechanical means, charts, photographs, notebooks, drawings, plans, inter-office communications, intra-office and intra-departmental communications, transcripts, checks and canceled checks, bank statements, ledgers, books, records or statements of accounts, and papers and things similar to any of the foregoing, however denominated.

2. The terms "relating," "relate," or "regarding" as to any given subject means anything that constitutes, contains, embodies, identifies, deals with, or is in any manner whatsoever pertinent to that subject, including but not limited to records concerning the preparation of other records.